215 ILCS 180/35 Health Care External Review Act

Sec. 35. Standard external review.

(a) Within 4 months after the date of receipt of a notice of an adverse determination or final adverse determination, a covered person or the covered person's authorized representative may file a request for an external review with the Director. Within one business day after the date of receipt of a request for external review, the Director shall send a copy of the request to the health carrier.

(b) Within 5 business days following the date of receipt of the external review request, the health carrier shall complete a preliminary review of the request to determine whether:

(1) the individual is or was a covered person in the health benefit plan at the time the health care service was requested or at the time the health care service was provided;

(2) the health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but the health carrier has determined that the health care service is not covered ;

(3) the covered person has exhausted the health carrier's internal appeal process unless the covered person is not required to exhaust the health carrier's internal appeal process pursuant to this Act;

(4) (blank); and

(5) the covered person has provided all the information and forms required to process an external review, as specified in this Act.

(c) Within one business day after completion of the preliminary review, the health carrier shall notify the Director and covered person and, if applicable, the covered person's authorized representative in writing whether the request is complete and eligible for external review. If the request:

(1) is not complete, the health carrier shall inform the Director and covered person and, if applicable, the covered person's authorized representative in writing and include in the notice what information or materials are required by this Act to make the request complete; or

(2) is not eligible for external review, the health carrier shall inform the Director and covered person and, if applicable, the covered person's authorized representative in writing and include in the notice the reasons for its ineligibility.

The Department may specify the form for the health carrier's notice of initial determination under this subsection (c) and any supporting information to be included in the notice.

The notice of initial determination of ineligibility shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Director by filing a complaint with the Director.

Notwithstanding a health carrier's initial determination that the request is ineligible for external review, the Director may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director's decision shall be in accordance with

the terms of the covered person's health benefit plan, unless such terms are inconsistent with applicable law, and shall be subject to all applicable provisions of this Act.

(d) Whenever the Director receives notice that a request is eligible for external review following the preliminary review conducted pursuant to this Section, within one business day after the date of receipt of the notice, the Director shall:

(1) assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director pursuant to this Act and notify the health carrier of the name of the assigned independent review organization; and

(2) notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review and the name of the independent review organization.

The Director shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may, within 5 business days following the date of receipt of the notice provided pursuant to item (2) of this subsection (d), submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after 5 business days.

(e) The assignment by the Director of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis among those independent review organizations approved by the Director pursuant to this Act.

(f) Within 5 business days after the date of receipt of the notice provided pursuant to item (1) of subsection (d) of this Section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination; in such cases, the following provisions shall apply:

(1) Except as provided in item (2) of this subsection (f), failure by the health carrier or its utilization review organization to provide the documents and information within the specified time frame shall not delay the conduct of the external review.

(2) If the health carrier or its utilization review organization fails to provide the documents and information within the specified time frame, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(3) Within one business day after making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination under item (2) of this subsection (f), the independent review organization shall notify the Director, the health carrier, the covered person and, if applicable, the covered person's authorized representative, of its decision to reverse the adverse determination.

(g) Upon receipt of the information from the health carrier or its utilization review organization, the assigned independent review organization shall review all of the information and documents and any

other information submitted in writing to the independent review organization by the covered person and the covered person's authorized representative.

(h) Upon receipt of any information submitted by the covered person or the covered person's authorized representative, the independent review organization shall forward the information to the health carrier within 1 business day.

(1) Upon receipt of the information, if any, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review.

(3) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

In such cases, the following provisions shall apply:

(A) Within one business day after making the decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the Director, the covered person and, if applicable, the covered person's authorized representative, and the assigned independent review organization in writing of its decision.

(B) Upon notice from the health carrier that the health carrier has made a decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

(i) In addition to the documents and information provided by the health carrier or its utilization review organization and the covered person and the covered person's authorized representative, if any, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) the covered person's pertinent medical records;

(2) the covered person's health care provider's recommendation;

(3) consulting reports from appropriate health care providers and other documents submitted by the health carrier or its designee utilization review organization, the covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) the terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier, unless the terms are inconsistent with applicable law;

(5) the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(6) any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization;

(7) the opinion of the independent review organization's clinical reviewer or reviewers after considering items (1) through (6) of this subsection (i) to the extent the information or documents are available and the clinical reviewer or reviewers considers the information or documents appropriate; and

(8) (blank

(j) Within 5 days after the date of receipt of all necessary information, but in no event more than 45 days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the Director, the health carrier, the covered person, and, if applicable, the covered person's authorized representative. In reaching a decision, the assigned independent review organization is not bound by any claim determinations reached prior to the submission of information to the independent review organization. In such cases, the following provisions shall apply:

(1) The independent review organization shall include in the notice:

(A) a general description of the reason for the request for external review;

(B) the date the independent review organization received the assignment from the Director to conduct the external review;

(C) the time period during which the external review was conducted;

(D) references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision;

(E) the date of its decision;

(F) the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards that were a basis for its decision; and .

(G) the rationale for its decision.

(2) (Blank).

(3) (Blank).

(4) Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.